OPTUM® | Maryland

Claims Rejection Report

Quick Reference Guide

This Quick Reference Guide explains how to read and download the Claims Rejection Report that will be automatically delivered using Secure File Transfer Protocol (SFTP) to the "download folder" of your Incedo Provider Portal account.

Optum Maryland is releasing two Claims Rejection Reports created to support providers during the claims estimated payment reconciliation process:

- **Report 1** (delivery on May 14, 2021) – will include rejected claims with dates of service from January 1, 2019, through June 30, 2020
- **Report 2** (delivery on May 14, 2021) – will include rejected claims with dates of service from service July 1, 2020, through March 30, 2021

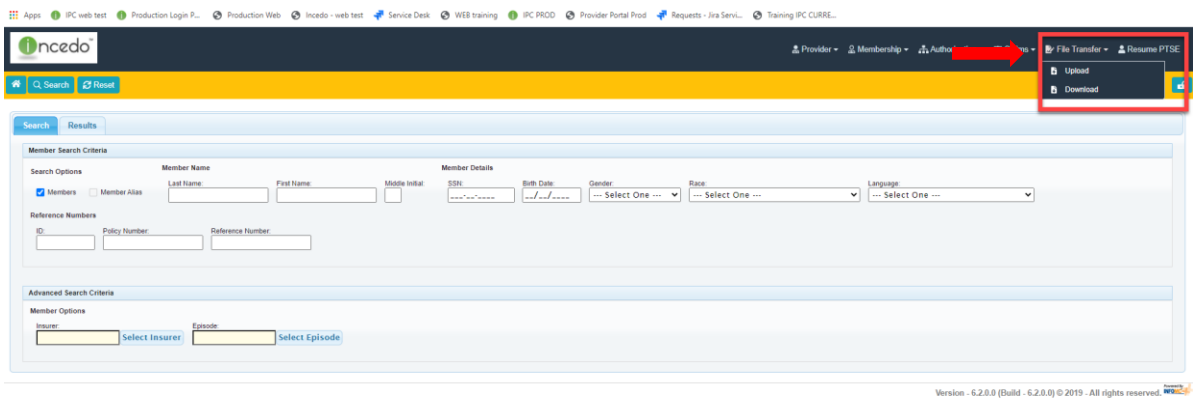
Following the delivery of the two reports, providers will receive a monthly report on the fourth Monday of each month to identify rejected claims that were not processed during the previous month, beginning on May 24, 2021 (i.e., the Claims Rejection Report delivered to providers on the fourth Monday in May will identify rejected claims during April).

The Claims Rejection Report identifies rejected claims that were never processed (and therefore, would not appear on a Provider Remittance Advice (PRA) with the corresponding explanation of the rejection. Providers can use this report to identify rejected claims for resubmission and processing. In addition, the Claims Rejection Report only includes claims that were submitted to Optum Maryland.

Claims Rejection Report – How to Download the Report

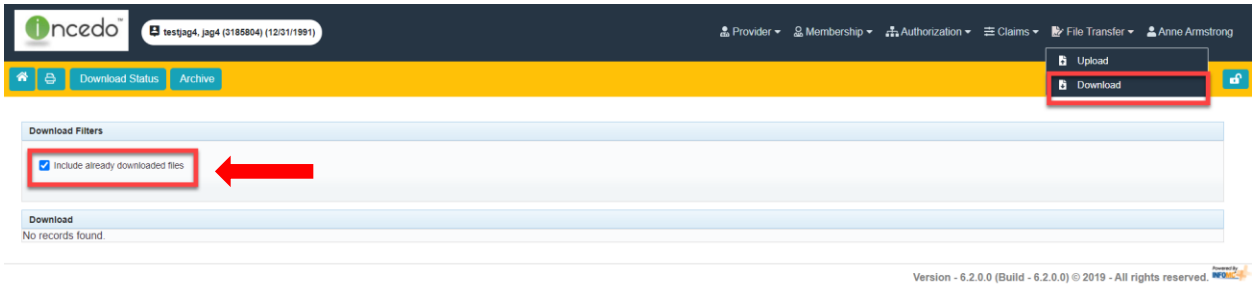
Providers can download and access the Claims Rejection Report by completing the following steps:

1. Log into the Incedo Provider Portal and go to the ***"download"*** screen, listed under the ***"file transfer"*** drop-down tab.



2. In the ***"download folder"***, you will see all items that have not yet been downloaded (To download, click on the file and open/save it).

3. There is a checkbox to display items already downloaded. This checkbox defaults to ***"unchecked"*** and will only show new items that have not been downloaded. Check the box to view all items; both new and those already downloaded.



Claims Rejection Report – Provider Action

The following steps should be completed upon receipt of the Claims Rejection Report:

Step 1 – Identify if you have:

- Resubmitted the rejected claim and have received a PRA/835 for the claim. If you have received a PRA/835, resubmission of the rejected claim is not required.
- Not received remittance for the rejected claim and confirm the most current status of the claim via the Incedo Provider Portal. If the claim remains in a rejected status, please ensure that the necessary corrections are made (as shown in the steps below) and submit a new claim.

Step 2 – View rejected claims and the corresponding rejection reason, and submit a new claim by following steps 3 and 4.

Step 3 – Correct the claim deficiencies according to the corresponding rejection reason found in the report by following the provider action listed in the Rejection Reasons table on page 4.

Step 4 – Submit a new claim if the original claim was rejected. This claim does not need to be marked as a corrected claim because the original was not adjudicated.

Please note the following:

- **Do not submit a corrected claim (i.e., Do not use Bill Type xx7 or Claims Frequency 7)**
- New claims may be submitted online via the Incedo Provider Portal, through a clearinghouse using Electronic Data Interchange with 837 batch files or by U.S. Mail
- New claims are subject to all adjudication rules

Claims Rejection Report – Important Reminders

Providers should note the following important reminders:

- This report includes rejected claims submitted via an 837, the Incedo Provider Portal, and paper claims that were never accepted into the system for adjudication
- Since these claims have not been processed through the system, there are no check numbers listed in the report, associated with claim lines.
- Claim lines may have more than one rejection reason. Optum stores up to two rejection reasons, therefore, there are two (2) "rejection reason" columns listed in the report.
- Data in one or more columns may appear blank (BLANK) in the report. This is due to:
  - No data available to populate in the field; or
  - The claim being rejected, therefore, data for those columns is not available.
- After carefully reviewing the Claims Rejection Report, please work with your Reconciliation Manager or email maryland.provpymt@optum.com for any questions or additional assistance.

The Claims Rejection Report will be delivered to providers as an Excel spreadsheet. A sample Claims Rejection Report with column header descriptions and an explanation of each section of the report is shown below. The images below provide a description of what each column header represents.

Claims Rejection Report: Section 1

Columns A - G of the Claims Rejection Report include claim number, claim line number, participant details, service dates.

A	B	C	D	E	F	G
Claim_Num	LineItemControlNumber	PatientFirstName	PatientLastName	PatientBirthDate	FROM_DATE	TO_DATE
201900000000	201900000000-10	OPTUM	MARYLAND	20060101		
201900000000	201900000000-10	OPTUM	MARYLAND	20060101		
201900000000	201900000000-10	OPTUM	MARYLAND	20060101		
201900000000	201900000000-10	OPTUM	MARYLAND	20060101		

A: Claim_Num - Claim number

B: LineItemControlNumber - Claim line item

C: PatientLastName - Participant's last name

D: PatientFirstName - Participant's first name

E: PatientBirthDate - Participant's date of birth

F: FROM_DATE - Date of service

G: TO_DATE - Date of service completion

Claims Rejection Report: Section 2

Columns H and I of the Claims Rejection Report include claims rejection reasons.

H	I
Rejection Reason 1	Rejection Reason 2
Member does not have a treatment for specified provider and level of care	Invalid Diagnosis for Service Provided
Member does not have a treatment for specified provider and level of care	Invalid Diagnosis for Service Provided
Member does not have a treatment for specified provider and level of care	Invalid Diagnosis for Service Provided
Member does not have a treatment for specified provider and level of care	Invalid Diagnosis for Service Provided

H: Rejection Reason 1 - See the table below to view a list of rejection reasons

I: Rejection Reason 2 - See the table below to view a list of rejection reasons

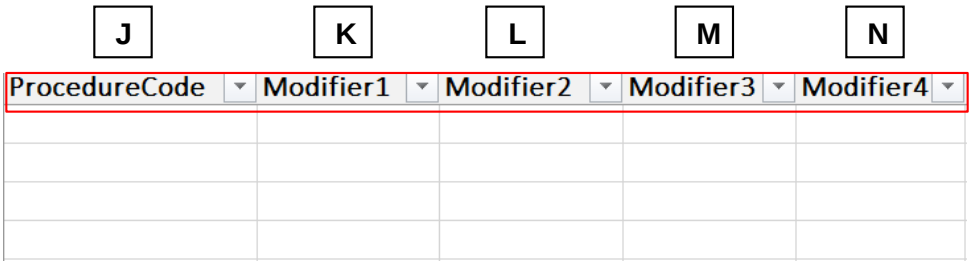
For any claim processed by Optum Maryland starting January 1, 2019 - June 30, 2020, several different rejection reasons were utilized.

Rejection Reasons	Description	Provider Action
Unable to match a member	Unable to identify the participant or we have multiple participant records for that member.	New claim submission required that validates participant demographics.
Claim cannot be created, no matching COB record for the member	Either no Third Party Liability (TPL) information on file in Incedo when present on the incoming claim file or TPL on file in Incedo but not presented with the claim file.	Validate that the eligibility system has Third Party Liability (TPL) information consistent with the claim that was submitted. If the eligibility system does not have TPL for the participant, submit the claim with an EOB and work with the participant to update the local authority with their other carrier information. If the eligibility system has TPL information, bill the other carrier first and then bill Optum Maryland, including the EOB from the other carrier.
Member does not have a treatment for specified provider and level of care	Multiple service, level of care, and authorization matches exist; manual matching is required.	Validate service, diagnosis and authorization. Resubmit claim(s).
Unable to match treatment provider site	During processing, the platform found multiple sites with provider setup.	Validate provider billing information and resubmit claim(s).
Claims from Provider Types 20, AB, 27, & 34 MUST have a Rendering Provider	Missing required rendering identifier.	New claim submission with a rendering provider is required if provider is a group.

Rejection Reasons	Description	Provider Action
Invalid Diagnosis Code	Missing or invalid Diagnosis Code per CMS.	New claim submission with valid diagnosis is required.
Claim detail lines cannot span dates. Must be single-day spans.	UB outpatient bill or Professional claim that spans multiple days.	New claim submission without date spans is required.
NDC is invalid for submitted Code/Modifier	NDC submitted is not valid, either in length or substance.	New claim submission including valid NDC is required.
Invalid Diagnosis for Service Provided	Missing or invalid Diagnosis Code per CMS.	New claim submission with valid diagnosis is required.
Missing Rendering Provider Primary Identifier	Box 32 partially filled in; this information is not used in claims adjudication.	Validate provider billing information and required rendering information the resubmit claim(s).
NDC is required for submitted Code/Modifier	NDC is required for one or more services submitted but was not billed.	New claim submission including required NDC is required.
Invalid CPT Code	Missing or invalid Procedure Code per CMS.	New claim submission with valid service is required.
Member has multiple treatments for the specified provider and level of care	Multiple service, level of care, and authorization matches exist; manual matching is required.	Validate participant information, services billed and diagnosis code. Then resubmit claim(s).
There is no match for the given CPT Code	Invalid CPT billed on claim.	Validate service billed and CPT code billed. Then resubmit claim(s) after validating and correcting the code.
Voided Claim Cannot Be Matched	A voided transaction was submitted, and the original claim could not be matched and located to be voided.	Please review the submission and correct the transaction and resubmit your void transaction.
Voided Claim	Original claim was successfully voided.	No action required
Voided Claim Received, Match Found and Voided	Original claim was successfully voided.	No action required

Claims Rejection Report: Section 3

Columns J - N of the ***Claims Rejection Report*** include procedure codes and modifiers.



J	K	L	M	N
ProcedureCode	Modifier1	Modifier2	Modifier3	Modifier4

J: Procedure Code – Service code

K: Modifier 1 - Modifier associated with procedure code

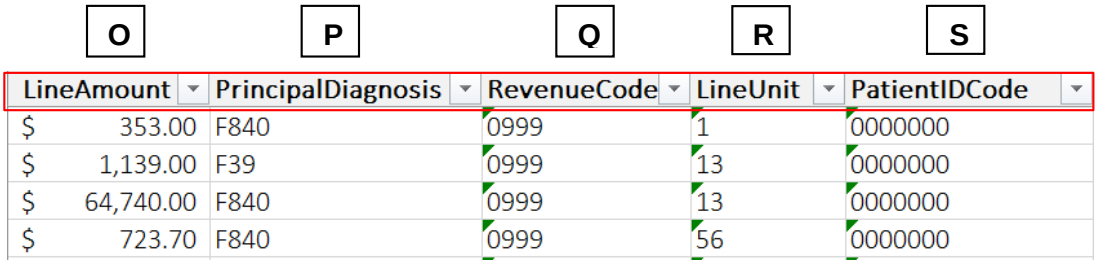
L: Modifier 2 - Modifier associated with procedure code

M: Modifier 3 - Modifier associated with procedure code

N: Modifier 4 - Modifier associated with procedure code

Claims Rejection Report: Section 4

Columns O - S of the ***Claims Rejection Report*** include line amount, principal diagnosis, revenue code, line unit, and patient ID code.



O	P	Q	R	S
LineAmount	PrincipalDiagnosis	RevenueCode	LineUnit	PatientIDCode
$ 353.00	F840	0999	1	0000000
$ 1,139.00	F39	0999	13	0000000
$ 64,740.00	F840	0999	13	0000000
$ 723.70	F840	0999	56	0000000

O: Line Amount – Billed amount specific to the claim line (Please note this is not the total billed amount.)

P: Principal Diagnosis

Q: Revenue Code

R: Line Unit – Number of units billed to the claim line

S: Patient ID Code – External policy number submitted on an 837/Maryland insurance number

Claims Rejection Report: Section 5

Columns T - AA of the ***Claims Rejection Report*** include the patient control number, provider TIN, short name, provider ID, NPI, place of service, batch number, and create date.

T	U	V	W	X	Y	Z	AA
PatientControlNumber	PROVIDER_TIN	SHORT_NAME	PROV_ID	NPI	PlaceOfService	Batch_Number	Create_Date
0000000000	000000000		0000000000	0000000000		0000000	02/11/2021
0000000000	000000000		0000000000	0000000000		0000000	02/11/2021
0000000000	000000000		0000000000	0000000000		0000000	02/11/2021
0000000000	000000000		0000000000	0000000000		0000000	02/11/2021

T: Patient Control Number – Providers' internal number used to track claims in their system

U: Provider TIN

V: Short Name - Name attached to the Incedo Provider Portal ID

W: Prov ID – Incedo Provider Portal ID

X: NPI

Y: Place of Service

Z: Batch Number – Optum Maryland internal reference

AA: Create Date